

## REQUESTING YOUR IMMUNIZATION RECORD

NOTE: Before beginning this process, it may be faster to request a copy of your immunization record directly from your current healthcare provider. If that is not possible, please read this information and complete the form below to request a copy of your immunization record, including your record of COVID-19 vaccination.

To obtain a copy of your immunization record, we use the Massachusetts Immunization Information System (MIIS), a web-based system that keeps track of all immunizations that healthcare providers administer to children and adults in Massachusetts. The system was established in 2011 and is operated by the Massachusetts Department of Public Health (MDPH) according to state law (M.G.L c. 111, Section 24M; 105 CMR 222).

**All individual information in the MIIS is kept confidential in accordance with a applicable law.**

To obtain your Immunization Certificate from MDPH, please submit the following and allow up to 10 business days for processing:

- A fully completed Immunization Record Request Form
- Completed Verification Questions (Page 2 of Immunization Record Request)
- You must return both pages of the Immunization Record Request for processing!
  - \* If you are making the request on someone else's behalf or as a minor's parent/guardian, you may be asked later for additional documentation demonstrating your legal authority to do so.

**\*Please note – the Immunization Certificate generated from the MIIS may or may not be a complete representation of the most current immunization status.** According to Massachusetts state law, healthcare providers and other licensed professionals must report administered vaccinations to the state; however, it is possible your provider has not yet: a) been registered to use the system; or, b) entered complete immunization history into the system. **Therefore, MDPH may be unable to provide you with an Immunization Certificate or may only be able to provide you with a partial record.** In this case, you will have to contact your healthcare provider to obtain your immunization records.

***Please return the completed paperwork to MDPH by mail or fax:***

**Massachusetts Immunization Information System (MIIS)  
Massachusetts Department of Public Health, Immunization Division  
305 South Street, Jamaica Plain, MA 02130**

**FAX: 857-323-8321**

# MDPH Immunization Record Request – Page 1

## Immunization Record Request Form

**Information on Record being requested:** This information is necessary to ensure the identity of the individual whose record is being requested (*i.e. you, your child, or individual over whom you have legal authority*).

NAME:

\_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH:   /  /   GENDER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

MOTHERS MAIDEN NAME: \_\_\_\_\_  
IF AVAILABLE FOR INDIVIDUAL YOUNGER THAN 18 YEARS OF AGE

**Information on Requestor of the record:** This information is necessary to ensure the individual/agency has the legal authority to complete this record request. Please include documentation as appropriate to confirm legal authority.

Requestor same as above – skip to **Signature of Requestor**, otherwise complete section below.

NAME:

\_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

RELATIONSHIP TO THE INDIVIDUAL NAME ABOVE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

I authorize the Massachusetts Department of Public Health to release the requested record to:

SELF                       HEALTHCARE PROVIDER                       SCHOOL                       OTHER  
AGENCY

AGENCY NAME: \_\_\_\_\_ VIA FAX: \_\_\_\_\_

AGENCY PHONE: \_\_\_\_\_

VIA MAIL:

\_\_\_\_\_  
STREET CITY STATE ZIPCODE

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Signature of Requestor:** I am requesting my own record, or I am the parent, guardian, or other person authorized to act for the person whose record I am requesting. I certify under the penalties of perjury that the information I am providing to request the identified immunization record is true to the best of my knowledge.

# MDPH Immunization Record Request – Page 2

## Immunization Record Request Verification Questions

Please complete as much of the following information as possible. You can skip a question if you do not have that information, but please fill out as much as you can. Having more information available helps MDPH verify patient records and process immunization requests in a timely manner. All questions below are pertaining to the immunization records being requested.

Please note that additional information may be needed to verify patient records and an MIIS representative from the MDPH may reach out to you for further verification.

Most Recent Immunization:

Vaccine Type: \_\_\_\_\_

Date Administered: \_\_\_\_\_

Administering Site: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number:

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Prior: \_\_\_\_\_

Current Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior Addresses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Primary Care Facility: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_